Minutes of Meeting

Health Services Council

Project Review Committee-I

DATE: 10 August 2004 TIME: 3:00 PM

LOCATION: Health Policy Forum

ATTENDANCE:

Committee I: Present: Edward F. Almon, Robert L. Bernstein, Marvin Greenberg, Robert S.L. Kinder, MD, Daniel F. McKinnon (Chair), Robert J. Quigley (Vice Chair), DC

Not Present: John Keimig, Robert Ricci, Robert Whiteside, John Young, William B. Zuccarelli

Other Members: Present: Larry Ross

Staff: Valentina D. Adamova, Michael K. Dexter

Public: (see attached)

1. Call to Order, Approval of Minutes and Conflict of Interest Forms

The meeting was called to order at 3:00 PM. The minutes of the 8 and 15 June 2004 meetings of the Project Review Committee-I were approved as submitted. Staff noted that conflict of interest forms are available to any member who may have a conflict.

2. General Order of Business

The first item on the agenda was the application of Rhode Island Hospital for a Certificate of Need to establish and operate a Pediatric Imaging Center and renovate the Hasbro Emergency Department.

Mr. Macri, Executive Vice President of Rhode Island Hospital, stated that Mr. Corderro would make the presentation for this project. He stated that this project meets the needs of the pediatric population, to have a comprehensive imaging center adjacent the Hasbro Children's Hospital and fits into the space that will soon be vacated by Davol's emergency room. He stated that Mr. Corderro will be assisted by Mr. Quitierio, Senior Project Manager and Lead Architect. He noted that the second project is to upgrade the surgical ICU and step down units. He stated that presentation will be made by Ms. Metzger, Chief Nursing Officer and Senior Vice-President, and will also be assisted by Mr. Corderro. He introduced Mr. Olmstead, Director of Shared Services, and Mr. Hiss, Director of Radiology Services.

Mr. Corderro, Vice President of Patient Support Services, made a

Power Point presentation to the Committee as follows:

· 2 years ago RIH was seeking replacement MRI, as a short term benefit in addressing pediatric need

· There is lack of dedicated pediatric imaging space to serve children. Children and adults are co-mingled.

· Transport with escort required to remote location is inefficient.

· Long wait times for advanced imaging studies for pediatric patient. The following are current wait times: CT – 5 weeks; MRI – 16 weeks; US – 5 weeks.

· Parental involvement helps the process and current facilities do not facilitate that. There is little room.

· This benefits the Hasbro ED because it turns existing vacated space into additional exam and treatment rooms.

· Patients' primary complaints in satisfaction surveys are crowded conditions of the waiting rooms, long waits to see someone and constrained space. This plan resolves those issues.

· There is lack of adjacency from the ED to the imaging department, and patients have to be escorted which creates patient safety and staffing issues.

· There are 2 phases to the PIC project.

· First part, the existing Davol ED is moved to the new construction in approximately April or May of 2005, and the vacated space renovated into a dedicated PIC.

· Second part, renovation of the vacated space in the Hasbro ED, and adding exam room capacity.

· The concept is to centralize pediatric imaging adjacent to the

pediatric ED by providing 98% of pediatric imaging services there.

· This plan provides convenient access, adequate space for pre and post procedures, and waiting rooms.

· The configuration will consist of 9 fully equipped imaging rooms as follows: 3 Plain Film Radiology, 4 Ultrasound, 1 MRI, and 1 CT rooms.

· The application includes acquisition of the following new equipment: 1 MRI, 1 CT, 2 Ultrasound, and 1 Plain Film Radiology.

· Pediatric demand will be strongest during the weekdays during the day, and during down time the proposed space will be used for adults.

· There will be additional 10 rooms in the pediatric ED, which will bring the total to 24 rooms to meet existing demand. The Hasbro ED currently sees 1/3 more patients that the space was designed for.

· There is a strong need in terms of quality care, safety and convenience for patients and staff. This will improve the ability to process patients.

· This will also decrease wait time, increase turnaround time, improve patient safety, improve management of image re-takes, the system will be PACS compatible (digitizes images), and increase staff efficiency, productivity and satisfaction.

· The first full year of operation for both phases will be in 2008. Capital investment for phase one is $9 million, and phase two $1.2 million, for a total of $10.2 million.

· The project will be funded by 100% equity, which includes grant proceeds and donor support.

Mr. Almon inquired as to why there are such high utilization rates, 1/3 more than capacity, in the Hasbro ED. Ms. Metzger stated that some hospital have reduced their pediatric inpatient capabilities. Mr. Greenberg asked by how much would the wait time be reduced because of this proposal. Mr. Corderro stated that given the additional equipment and staff, it is anticipated that regular outpatients would be seen for an MRI within a 48-hour period. To the question regarding the equipment for the rooms, the applicant noted that all of the costs are included in the application. The applicant stated that other hospital with pediatric services have seen an increase in the use of pediatric sedation and advanced modalities.

To the question regarding utilization rates, the applicant stated that the ED visits increased from 33,000 to around 42,000 to 45,000 over the last few years for pediatric services, and Davol ED services approximately 78,000 adult visits or approximately 125,000 total visits. Mr. Ross requested that the applicant identify 'Other Controllable Expenses', which is over $300,000, in the follow up questions. He inquired if additional staffing for Radiology is strictly related to the additional volume. The applicant agreed with that statement. Mr. Ross noted the application shows an addition of a physician position and asked what services that person would provide. Mr. Corderro stated that this position is a clinical Director function that allows a specialized clinician to look into quality and that it's a specialist in pediatric care.

Mr. Corderro stated that in terms of incremental changes the project would increase by 18,264 the number of imaging studies, and add 18.8 FTEs. He noted that incremental expenses and revenue would be $4,732,000 and $4,482,000 respective for a net income of $250,000.

Mr. Quitierio presented the design overview.

Mr. Greenberg inquired as to when the construction would start. Mr. Quitierio stated that it would begin in the spring when the Davol space becomes vacated. Mr. Corderro stated that the ultimate goal is to segregate the pediatric and adult patient. He noted that even when adult would use PIC during down town, the design would allow for segregation. He stated that there would be new and current equipment used in the proposed PIC.

Mr. Almon noted that the proposed area for the PIC cannot be physically expanded, and inquired if there is a contingency plan for expansion. The applicant noted that not all of the space would be utilized and some area is being reserved for future flexibility.

The next item on the agenda was the application of Rhode Island Hospital for a Certificate of Need to Upgrade Surgical Intensive Care and Step Down Beds.

Ms. Metzger, Senior Vice President and Chief Nurse Officer of Rhode

Island Hospital, made a Power Point presentation to the Committee as follows:

· Existing 39 Surgical ICU Step Down ("ICU") beds and 10 General Surgical ("General") beds are 40 years old and do not comply with AIA guidelines.

· The proposed new rooms would be universal rooms, which allow any level of care to be provided in those rooms.

· Most of rooms are double rooms, and there is rising incident in infections diseases, which require isolation and the need for private rooms.

· 3 of current ICU do not qualify as double rooms and are open wards. Both JACHO and the Rhode Island Department of Health have cited those units as inappropriate for providing patient care.

· Currently the surgical ICU is on the 4th floor, surgical step down unit on the 5th floor and trauma ICU is on the 5th floor which is not efficient. This requires transferring patients between floors.

· The proposal would consolidate and move the nurse to the patient. Consolidation would enhance physician/resident coverage and increase efficiencies.

Mr. Quitierio showed pictures as part of the Power Point presentation that showed the current space inadequacies.

Ms. Metzger continued with the Power Point presentation as follows:

· Last year the north and east wings of the 4th floor of the main building were renovated. 16 ICU beds were brought up to the current

AIA guidelines, by improving the air-conditioning and elliptical upgrade.

· Second project currently in process is the renovation of the south wings of the 4th and 5th floors. This will convert 9 ICU beds and 11 General beds into 16 ICU beds and add 4 private rooms.

· The proposed application is phase 3 and 4.

· In the beginning of phase 3, there will be 18 ICU beds and 10 general beds, and at the end of this phase there will be 36 ICU beds. This is a net gain of 18 ICU beds and a loss of 10 General beds.

· In the beginning of phase 4, there will be 21 ICU beds and 0 general beds, and at the end of this phases there will be 15 ICU beds, which is a net loss of 6 ICU beds.

· For the overall CON project there is a gain of 12 ICU beds and loss of 10 General beds.

· Overall effect of the 4 phases creates a gain of 19 ICU beds and a loss of 21 General beds.

· This project would also included changes from semi-private to private beds.

· In the beginning of phase 3, there will be 28 semi-private and 0 private beds. At the end of that phase, there will be 18 semi-private and 18 private, which is a loss of 10 semi-private and a gain of 18 private beds.

· In the beginning of phase 4, there will be 17 semi-private and 4 private beds. At the end of that phase, there will be 2 semi-private and 13 private beds, which is a loss of 15 semi-private and a gain of 9 private beds.

· For the overall CON projects there is a loss of 25 semi-private and a gain of 27 private beds.

· Overall effect of the 4 phases creates a 31 loss of semi-private and a 29 gain of private beds.

· In terms of public need, the community deserves access to a state of the art ICU, more private rooms, and more efficiency in the trauma center.

· The hospital projected the need and estimated there to be 3,451 new surgical and 907 new ICU/Step Down cases by FY'10. This would require 83 ICU beds @ 85% occupancy versus current supply of 64 ICU beds.

Staff inquired if general beds would be converted into ICU beds how would that be affected if some of the new surgical cases of 3,400 require general beds. Ms. Metzger stated that this is a ramp up in volume of 3,400 over time until FY'10 and these rooms would be universal to accommodate any level of care. She also stated that a unit could be opened to meet additional volume. She noted that there is a plan to propose another CON. Staff inquired as to what universal room range capabilities are. Ms. Metzger stated that it is from general to insensitive care level C.

Ms. Metzger continue with the presentation as follows:

· Based on the projections there is a need for 19 more ICU beds.

· In phases 1 and 2 there was a gain of 7 ICU beds and current application, phases 3 and 4, would provide 12 additional beds.

· The hospital is in the process of looking at bed demand and may be back if there are available resources.

· In terms of affordability for this proposal, the first full year of operation will be in FY'08 and the capital cost of both phases is $8.9 million. $7.4 million is for phase 3 because it is the expansion part of the project and $1.5 million for phase 2.

· The proposal will be funded 100% in equity.

· The incremental FTEs are approximately 14, and they are all RNs.

· Net income is projected to be $1.2 million.

Staff inquired as to when the planning in progress by the hospital that looks at looks at need for total patient beds would be finished. The applicant stated that the hospital has come to the conclusion of what is the most economical approach but hasn't done a market demand study to find out how much of that would need to be activated. He noted that the hospital is waiting to see what happened with the ED and Surgical projects. The applicant projected it would be back within 2 years for an additional project.

Mr. Quitierio presented the design overview. He noted that several years ago there was an addition to the back of the building to help with the central air-conditioning, and now that footprint will be used to build on top of that for each level. He noted that during construction there will be12 beds out of services at one time. He noted that the barrier between the construction and the existing building will be maintained until the hospital is ready to renovate the

entire wing.

Mr. Greenberg inquired as what the hospital is doing about the parking problem. The applicant stated that an additional 250 parking spaces will soon be opened and there is additional parking of 250 spaces to be completed by next May.

Mr. Ross inquired if the additional staffing is strictly related to the ICU beds. Ms. Metzger stated that it is related to the level of care at the ICU level and the staff that services the General beds is in the process of getting upgraded. Mr. Ross stated that the application identifies the capital costs and requested that the applicant identify the operating costs for the beds as they come on-line by each phase. He noted that it has been presented that in the first full fiscal year FY'08 there would an increase of 108 discharges and in FY'10 an increase of 907. The applicant stated that this increase is affected by the work in all other projects.

Dr. Kinder inquired as to the final bed count after this proposal. Ms. Metzger stated that the hospital's bed count would be reduced by 2 beds. To the question regarding the hospital licensed bed capacity, the applicant noted that the hospital is licensed for 719 beds and at the maximum there could be 609 operational. The applicant stated that it is anticipated that the hospital will be bringing more beds on-line.

The Committee scheduled a site visit to Rhode Island Hospital for 24 August 2004.

There being no further business the meeting was adjourned at 4:10 PM.

Respectfully submitted,

Valentina D. Adamova